FLU VACCINE SCREENING FORM

Patient's Name _____ **Date of Birth** ____/____/____ **AGE** ____
(mo) (day) (yr.)

For parents/guardians: Please answer the following screening questions next to your child's age by circling the correct answer. Please ask the nurse or doctor to explain if any questions that are not clear. There are 3 additional questions on the 2nd page.

If your child's age is between		YES	NO	Office Use Only
Birth up to 6 mos	1. Is your child less than 6 months of age today?	**Y**	**N**	DNV
	2. Are there other children in the home under 19 years of age? (If yes, request individual screening form for each child.)	**Y**	**N**	Y – screen by age
6 mos up to 24 mos	1. Has the child ever received flu vaccine before?	**Y**	**N**	SS - (PF) 0.25 ml Y – 1 dose N - 2 doses
	2. Are there other children in the home under 19 years of age? (If yes, request individual screening form for each child.)	**Y**	**N**	Y – screen by age
24 mos up to 3rd birthday	1. Does your child have any of the following conditions? a. Heart or breathing conditions, including asthma b. Diabetes c. Blood conditions e.g. Sickle Cell Anemia d. Chronic aspirin therapy e. Cancer, leukemia, AIDS, or any other immune system problem?	**Y**	**N**	Y – SS – (PF) N – PP 0.25 ml
	2. Are there any children in the home under 2 years of age? (If yes, request individual screening form for each child.)	**Y**	**N**	
	3. Does the child live with someone who has any of the medical conditions listed in # 1 above or is over 65 years of age?	**Y**	**N**	
	4. Has the child ever received flu vaccine before?	**Y**	**N**	Y – 1 dose N – 2 doses
3 years up to 9th birthday	1. Does your child have any of the following conditions? f. Heart or breathing conditions, including asthma g. Diabetes h. Blood conditions e.g. Sickle Cell Anemia i. Chronic aspirin therapy j. Cancer, leukemia, AIDS, or any other immune system problem?	**Y**	**N**	Y– SS N – PP 0.5 ml
	2. Are there any children in the home under 2 years of age? (If yes, request individual screening form for each child.)	**Y**	**N**	
	3. Does the child live with someone who has any of the medical conditions listed in # 1 above or is over 65 years of age?	**Y**	**N**	
	4. Has the child ever received flu vaccine before?	**Y**	**N**	Y – 1 dose N – 2 doses

If your child's age is between		YES	NO	Office Use Only
9 years up to 19th birthday	1. Does your child have any of the following conditions? a. Heart or breathing conditions, including asthma b. Diabetes c. Blood conditions e.g. Sickle Cell Anemia d. Chronic aspirin therapy e. Cancer, leukemia, AIDS, or any immune other system problem	**Y**	**N**	Yes – SS No – PP 0.5 ml 1 dose
	2. Are there any children in the home under 2 years of age? (If yes, request individual screening form for each child)	**Y**	**N**	
	3. Does the child live with someone who has any of the conditions listed in # 1 or is over 65 years of age?	**Y**	**N**	
	4. Is the child/teen pregnant?	**Y**	**N**	

Additional Questions (for ALL children)

1. Is the child sick today?	**Y**	**N**	
2. Does the child have allergies to medications, food, or any vaccine? (**eggs, gelatin, Thimerosal, neomycin, polymyxin B)**	**Y**	**N**	
3. Has the child had a serious reaction to a vaccine in the past?	**Y**	**N**	
4. Is the child on any medication? If yes, please list:	**Y**	**N**	

"I have been given a copy and have read, or have had explained to me the information in the Vaccine Information Statement for Influenza. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine. I request that the vaccine indicated below be given to me or to the person named below for whom I am authorized to make this request.

Child's Name: _____ **Birthdate:** _____

Parent/Guardian Signature: _____

OFFICE STAFF TO COMPLETE

Influenza Vaccine	Date Given	Dose in Series	Dosage	Route	Site	Vaccine Manufacturer and Lot #	VIS Material Pub Date	Signature and Title of Person Administering Vaccine
Fluzone – PF Fluzone Fluvirin LAIV		1 2		IM				

☐ Recall for 2nd dose